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BULLETIN of the
MENNINGER CLINIC

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THE INITIAL PHASE OF PSYCHOTHERAPY*

By JULES V. COLEMAN, M.D.†

The patient arriving for his first psychotherapeutic interview has very little idea of what is expected of him or of what to expect from the psychiatrist. The first requirements at the beginning of treatment, then, are: orientation of the patient in the process of treatment, clarification of the patient's feelings about treatment and about the therapist, and establishment of a treatment situation in which the balance between regressive and integrative trends in the patient may be maintained at a level most appropriate to the nature of his presenting problem.

From this point of view, psychotherapy becomes a very highly adaptive procedure on the part of the psychiatrist, since it depends upon the nature of the precipitating problem, its relation to underlying personality needs and to the character structure, the extent of the patient's transference resistances and his tolerance of anxiety, and the orientation and skill of the therapist. The psychiatrist sets up and controls the conditions of treatment, but he must also be extremely flexible in adapting these conditions to the requirements of his patient. For this reason, while the skilful use of techniques is important, psychotherapy cannot be reduced to a series of technical manoeuvres, or to a method of stereotyped response, or to a few limited technical principles, but relies at every point on a thoughtful dynamic evaluation of the patient's response to treatment and of the course of treatment itself.

The "free-floating attention" which Freud describes as the attitude of the analyst, and which may be further characterized as an attitude of reflective assimilation, is also necessary in psychotherapy, since it guides and maintains the activity of the therapist. However, the important difference is that in psychotherapy there is a much greater need for focusing activity by the therapist, particularly in the early stage of treatment. This activity is directed at creating a therapeutic situation which avoids any undue stimulation of regressive impulses, while at the same time providing the

* Condensed from a paper presented at a meeting of the Topeka Psychoanalytic Society, Topeka, Kansas, May 14, 1949.

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dependency gratifications without which there can be no treatment at all, and helping the patient to maintain an interest in current problems.

There are several procedures which are found useful in setting up and maintaining a therapeutic situation of this nature, and conversely, there are a number of pitfalls which must be identified and avoided.

On the positive side, the reality aspects of the treatment relationship are given consistent attention by the therapist, who must be alert to the following questions which he raises for himself: Why does the patient come for treatment at this particular time? What are the current conflicts in his life situation which are so troublesome and create so much anxiety that he finds it necessary to turn to another person for help? Since the patient applying for treatment is in a regressive position to start with, what are his transference identifications, to what extent and how will he attempt to manipulate or control the relationship on a transference basis, or in other words, what infantile demands does he seem to be making of the therapist?

As an example of the place of reality focus in maintaining the integrative-regressive balance, I shall briefly discuss the opening interviews in the case* of a 28 year old white married male, who had been depressed for several months since he learned his wife was pregnant. The patient had poliomyelitis in infancy, with crippling of the right leg, and felt rejected by his parents. The first interview revealed that the patient was moderately depressed; that he seemed extremely dependent on his wife; that he felt worthless, rejected, unloved, and malformed; and that he felt overwhelmed by his murderous impulses toward the unborn child. He was convinced that he could not have a normal child. He said, "I am a bastard. The child will be a bastard."

The patient displayed considerable overt hostility, a "chip-on-the-shoulder" attitude toward the therapist in this interview, indirectly expressing doubts about treatment and about the therapist's ability to help him. The therapist's comments were mainly reflective, echoing what the patient said by the use of a word or phrase. No attempt was made to comment on the patient's hostility, and this was wise since the more dominant feelings were his anxiety and depression. However, the sympathetic reflective comments were not sufficiently helpful; they were useful but needed to be supplemented by comments which would draw the patient's attention to the presenting problem, i.e., his inability to share his wife with the baby.

On the basis of the structuring of the first interview, in which avoidance of any reference to the current conflict led to stimulation of regressive tendencies, the patient brought up a good deal of material in the next two interviews about his parents, his feelings that they had mistreated him,

* The case material presented is taken from supervisory conferences.

and particularly that his physician father could have secured better treatment for him at the time of his poliomyelitis. As the therapist began to focus the patient's interest on his hostile feelings toward the wife and child, the patient was able to express several signs of change in attitude concerning the present conflict, and treatment movement began to take place.

There are other procedures which are useful in avoiding undue stimulation of dependency cravings in patients. However, I might first observe that dependency gratifications must be given the patient in treatment, and that these procedures are intended not to relieve the therapist of his anxiety concerning the dependency demands of his patients, but rather to maintain the reality motivations which will make it possible for the patient to deal with the current conflicts underlying his symptomatology.

The first of these procedures is the spacing of interviews. A schedule of once a week generally works out very well for the average clinic patient. More frequent interviews require much greater skill in management. A schedule of three or more interviews is indicated in the first week or two for patients who show extreme anxiety or acute depression. Many therapists seem to be under the illusion that frequent interviews will speed up the treatment process, when actually it does the reverse, since it deepens the regressive position of the patient, intensifies dependency needs, and sidetracks current reality issues.

Another procedure consists of picking up for discussion any remarks the patient makes about improvement, and commenting upon them as a wish to end treatment. Since such remarks by patients begin to come up fairly early in treatment, it keeps the patient thinking of his original motive for seeking help, and makes it possible for him to evaluate his own situation realistically as he goes along. Sometimes, when a patient mentions improvement, termination may be the thought furthest from his mind, yet even then it is of value to pick it up in this way. For example, a female patient had come for treatment because of a fear that she was becoming insane. In her interviews, she gradually revealed persistent and painful feelings of inadequacy, of being unlovable, and of great dependency on the therapist. As an expression of her dependency, she maintained a steady flow of complaints about herself, minimizing the help she was getting, for the purpose of prolonging treatment. At one point she said she had been feeling better during the previous week, and the therapist pointed out to her that she was saying that in order to reassure him, and to keep him from getting too discouraged, but then added that he thought she also recognized by the remark that she had been helped with her original problem, and had some idea about stopping treatment. This brought forth a storm of protestation, which continued for several interviews, but

did serve the purpose of permitting at least a discussion of termination, and the beginning of preparation for what would be in any case a stormy ending period.

Some help in avoiding dependency excesses can also be obtained by allowing the patient to feel completely free to decide in the first place whether he wants treatment, and then to continue to give him the freedom of deciding each time whether he wants to return for the next interview. The patient when asked if he wishes to return will often respond by asking, "What do you think, doctor?" When this happens, the best reply is to point out to the patient that he is not sure that he does want to return, and then allow him to deal with the feelings he has about making the decision.

Occasionally there is the patient who is so insecure and so fearful in his anticipation of rejection that the therapist must be careful to avoid asking him to make the decision to continue treatment, but instead suggest the hope that he would like to continue, together with reassurance about the therapist's interest and concern. For example, there was the man in his middle thirties who came to treatment after two years of steady social deterioration, during which he had lost his business, his family, and his friends. In the first interview, he sat with his chair turned away from the therapist, eyes down, with constant restless movements of his hands and body, expressing in his every word and gesture a complete despair that anyone would be interested in wanting to help him or would care what might happen to him. Here the therapist needed to be very active in supporting and encouraging his dependency needs, and assuring him that she wanted to see him again on a regular interview basis.

An occasional patient comes to the psychiatrist with a fairly well defined current conflict, which he is able to bring into focus early in treatment, and keep in focus while he deals with the anxieties associated with the conflict. This is the unusual situation of a patient with an excellent capacity for integrative ego activity, and here the role of the doctor can be very passive, limited to reflective and occasional focusing comments. It is especially important in these cases to avoid the temptation to elicit historical material or to divert in any other way from the patient's self-regulating movement in treatment.

More often, however, one encounters varying degrees, kinds, and expressions of initial resistances, which in general need to be recognized and discussed as they begin to emerge. Most patients are at first fearful of treatment and fearful of the therapist and his reaction to them. They present many doubts about the ability of the therapist to help them, to understand them, to appreciate their problem, to respect them as people, and to be able to regard them with sympathy and without ridicule or re-

jection. Sometimes it takes a number of interviews before the problem begins to emerge, and in the meantime the patient has been testing the therapist's tolerance, willingness to take the side of the patient against the world, and incidentally the side of his neurosis against reality.

Early resistance may take the form of absence of associations, where the patient says, after presenting his symptoms, "I don't know what to talk about. What would you like me to tell you?" This may be handled with the suggestion that the patient is free to talk about anything he likes, a comment which puts the patient under considerable pressure. Or the suggestion is made that the patient talk about his family or his recent experiences or some phase of his childhood, and this relieves the patient of any responsibility for discussing the problem which brought him to treatment. Both approaches, while widely used, are open to question since they fail to deal with the actual and immediate problem, which is the patient's sense of insecurity in approaching treatment, his anxieties about the therapist, and his testing of the infantile gratifications he may expect from treatment.

Marked hostility is sometimes found initially in patients with dependency demands to which they give pseudo-reality justification, following the formula: I have been injured by you, now you must take care of me. This is seen, for example, in veterans applying for treatment in VA clinics, especially when they have been through a long period of medical work-up, on the one hand, or ineffective psychiatric hospitalization, on the other. They feel that the consideration they are requesting is their right and their due, and start off with expressions of displaced hostility, talking about their previous medical experiences in a hostile way which can be easily recognized as actually referring to the present treatment situation.

In some of these cases, anxiety seems completely submerged by the patient's sense of being justified in his thinly veiled procedure of maligning and depreciating the therapist; and unless these expressions are recognized and brought to the patient's attention for discussion, they will tend to become augmented and more direct, and lead to rapid termination of treatment. The patient who talks in the first interview, for example, about having been treated, while he was in the Navy, by the two best psychiatrists in the country, is obviously expressing an unfavorable evaluation of his present therapist. At the same time, the patient who is frankly and repetitively critical of previous treatment, is probably expressing his opinion of psychiatrists in general and also of his present therapist in particular.

Often, however, attitudes of defiance, resentfulness, doubt and criticism toward the therapist represent a shallow façade intended to cover the patient's fears of rejection, his anxiousness about making a favorable impression, and his feelings that nobody can really be interested in wanting to

help him. Here it may be helpful to by-pass the early hostile resistance by focusing directly on situational problems through questions and comments, instead of pointing out the relationship between the hostility and the patient's uneasiness in the treatment situation.

There are many ways in which patients reveal their resistance to treatment, their difficulty in dealing with the situational conflict which brought them to the psychiatrist. The patient's presence is no proof that he is ready to deal with his problems. There are of course many sources of initial resistance. They may be embedded in the neurosis, in the life situation, or in the immediate reaction to treatment. The prognosis in psychotherapy can be established early, within the first few interviews, by testing the patient's capacity to deal with his initial resistance, i.e., by the response to efforts by the therapist to clarify the patient's reactions to treatment, and to establish discussion in relation to the situational problem.

The most common defense encountered in the first few interviews is persistent discussion of symptoms. The patient talks about all the details of his complaints, and at the end of the interview one has no idea what his life situation is, what current problems he is dealing with, whether he is single or married, has parents or siblings, works or goes to school. Actually, there is no reason for allowing a recital of symptoms to go on indefinitely. The therapist can make the comment that the patient is uneasy about treatment, or that he is having trouble in talking about his personal affairs, or that he has some doubts about the helpfulness of treatment, or the like. In other words, one directs attention from content to process, to the patient's purpose in presenting the material, to its implication as resistance.

On the other hand, when the flow of talk is under the pressure of anxiety, or where acute anxiety is interfering with an easy flow of associations, it becomes the responsibility of the therapist to lend a hand with sympathetic and reflective comments, in order to reduce the anxiety, and put the patient at his ease. Sometimes the uneasy and faltering patient needs a good deal of help in the form of early interpretation of his anxiousness, uncertainties, and doubts concerning treatment, before he can begin to talk freely.

Another common defensive measure is intellectualization, the use of psychological terms, a compulsive need to explain everything, the effort to get the therapist into general discussions, and so on. Long pauses in the beginning of treatment present a particularly trying problem to the therapist. They represent a form of acting-out, negativistic behavior which is intended to test magically the therapist's understanding, and at the same time to express defiance. Back of it is the attitude: You are the doctor, you should know, I should not have to tell you. It can often be handled

by its active interpretation as a manipulative trend, but sometimes must be waited out.

In initiating the process of treatment, it is important to allow the patient to learn that he is responsible for bringing material related to the precipitating conflict. This is done at first by an attitude of listening, and of expectant waiting for the patient's remarks. The process of clarification, i.e., of interpretive comments about the patient's feelings toward treatment and the therapist, is further intended to clear the way for the patient so that he can more readily disclose the problem which brought him to treatment.

It does very little good to explain to the patient what treatment is about, to try to persuade him that he needs treatment, or even to encourage him, in most instances, to come for treatment. It is practically useless to try to give a patient any understanding of the emotional or psychological basis of physical symptoms. One has to assume that the patient can be treated only if he is able to respond to the helping relationship offered by the therapist, and that if the therapist, in the first interview, follows the course outlined above, the patient will not need or ask for any further explanation. In other words, the treatment process is presented to the patient by demonstration rather than explanation, by giving him the opportunity of participating at once in a treatment experience.

It is important to introduce patients to treatment immediately, and not first to subject them to any formal diagnostic process. The diagnostic information which is needed for treatment can be obtained through the treatment interviews themselves, at least with clinic patients. One aspect of self-discipline on the part of the therapist consists in avoiding needless questioning of the patient. In this respect, some experience with children's cases can be very instructive. However, while children simply ignore the inappropriate question, adults are overtly more polite but actually give little in response which is meaningful for treatment. The ill-timed question may be an effort by the therapist to fill a void of silence, or it may be idle technical curiosity, or it may represent an effort to steer the patient's interest in this or that direction, or simply to stimulate the patient's productions. Particularly uncalled for is the practice of asking patients how they feel about conflict material, since they can hardly be expected to know.

The continuous asking of questions with the adult patient may have the same effect as the failure to establish limits in treatment of the child, i.e., it encourages aggressive and acting-out behavior. The main indication for the asking of questions is to help the patient in bringing out the details of the current conflict when he is actually engaged in the process of doing so. Here, too, however, the right of the patient to present material in his

own way must be respected, especially since observation of the way he does it may provide valuable leads for the therapeutic work.

In the process of psychotherapy, the psychiatrist allows the patient to bring the material which he needs to deal with, and then limits himself, as much as possible, to comments on the material. In other words, the therapist follows the patient, waits for problems to begin to emerge, or, through clarification, helps the patient bring out the conflicts which are troubling him.

There are six types of comments which are commonly used in psychotherapy, and these are sympathetic, reflective, focusing, facilitating, confronting, and connecting comments. The sympathetic comment offers to the patient an appreciation of his difficulties. A common way of putting it is: "You've had a tough time," or something similar. Its effect is to create in the patient a feeling of being appreciated, understood, and supported. Patients with good integrative ego capacities may do very well in working out situational anxieties in response to such comments.

Reflective comments have very much the same effect. They consist in echoing or rephrasing what the patient has said. The patient accepts such a comment as endorsement and approval, and is stimulated in the production of material of a similar nature. Such comments are therefore useful in helping to maintain a flow of associations, particularly on a superficial level. They are also helpful, as are sympathetic comments, in putting the patient at ease in the first interview or two, and in helping him to develop confidence in the therapeutic process. They tend to establish a therapeutic situation early but they make little contribution toward helping patients deal with painful or difficult material, except in the very mild problems which rarely come to a psychiatrist anyway.

Focusing is the process of selecting from the associative flow the material of special interest to the therapist. Focus can be established by the use of single or repeated comments or questions, or by raising an eyebrow. It is the principal device by which any particular theory of psychotherapeutic practice is applied. Its effect depends upon the need for compliance which is found in all patients who are able to move into a therapeutic situation. It is the chief method of helping patients to understand what is expected of them in the psychotherapeutic process. In the method under consideration here, it is used principally to maintain the patient's interest in his reactions to treatment, to the therapist, and to current life situations.

The facilitating comment brings to the patient's awareness an area of preconscious material which is beginning to emerge but which is still so charged with anxiety that the patient cannot bring it to conscious consideration without assistance. Here we move into the area of specific interpretation of conflict material.

The confronting comment directs the patient's attention to material which he is not prepared to deal with; initially it is usually met with denial. Again, it brings to the surface preconscious material, either of a hostile nature, or related to the patient's defensive system. In the beginning of treatment it is used primarily for purposes of clarification. It is the type of comment which is used in the beginning particularly to work through treatment resistance, and frequently in later stages in helping patients to deal with material which is deeply charged with anxiety.

In the connecting comment, the historical basis for current attitudes is uncovered, or more generally, one establishes a relation of similars of which the patient had been unaware. It begins to be useful in long-term cases, and is almost never of value at the beginning of treatment. In dealing with historical material, it is effective not so much in bringing about insight, but in reducing the patient's guilt about present attitudes and impulses by helping him to see their genetic sources. The patient's immediate reaction is: It is not my fault, it is their fault. However, this wears thin after a while, and the anxiety and guilt associated with the particular conflicts must be worked through in other of their complex inter-relationships. The connecting comment depends on abstraction or generalization, and may help to give the patient distance, perspective, and a sense of mastery, but it does often lend itself to profitless intellectualization.

Psychotherapy is thus an interpretive procedure, based on verbal recognition of conflict material. It deals with problems of conflict, resistance and transference. It attempts to create, in the treatment situation, an emotionally charged atmosphere in which an emotionally meaningful experience can be achieved. Its basic differences from analysis consist of the following: deliberate avoidance of intensive dependency reactions by the procedures outlined above; consistent attention to current situational factors by clarification and by discriminative focus; more active and more superficial interpretations by the therapist; and finally, limiting the duration of treatment by the more directed attention to current problems. The patient contents himself readily with limited treatment objectives when the therapist can allow him to do so.

THE CREATIVE ARTS AS THERAPY*

By MARY HUNTOON†

The modern concept of psychiatric treatment emphasizes the fact that the cure of the patient does not depend upon the physician alone, but upon the combined efforts of all the members of the psychiatric team, and upon the therapeutic atmosphere created in the hospital by this point of view. Recovery in the psychiatric patient means the discharge of his negative and destructive feelings in a harmless way, and a reinvestment of his positive and constructive feelings in the world of reality about him.

The recognition of the part that art can play in the modern psychiatric hospital has come, largely, from the medical and psychological profession, and not from the artist—a fact which I find significant. Freud[1] was interested in the therapeutic role played by the creative process in the man of genius. It is becoming increasingly clear that by means of the creative process the individual is able to keep his destructive tendencies in abeyance, and that this is applicable, not only to the man of genius, but to any individual.

It seems logical, therefore, that it would be possible to aid selected patients by stimulating their creative faculties. The selection of patients for this type of therapy, however, seems to depend more upon the patient's deep need for a mode of expression which will synthesize his inner states of mind, and upon his latent creative faculty, than upon any superficial facility in the different media of art. A statement attributed to Picasso[2] claims that a painting worthy of the name of art takes charge of the painter at a certain stage. In other words, when the creative process is aroused in a person, it acts as a liberating agent for unconscious material in his mind.

Art in Winter VA Hospital

A department of art was incorporated in the original set-up of Winter VA Hospital, and from the beginning it has been immensely popular with both the patients and the staff. It has been progressively used by physicians who saw their patients finding release and joy in the creation of inspirational material, and in the projection of their feelings upon canvas. Patients who had failed to respond to other specific modalities sometimes

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began their recovery in the studio. Other patients graphically portrayed their emotional problems, conflicts, and sometimes the solution or evolution of these in a form understandable even to the artistically unsophisticated doctor. Patients who had no conscious need to express themselves in art blossomed into creditable artists to the astonishment of doctors, nurses, therapists, and friends—and always to the amazement of themselves. Such phenomena are now so familiar to the therapists and doctors in this hospital that the place of creative art is unquestioned. This has led us to attempt to describe and analyze our work more specifically.

In the studio, many discussions arise as to modes of expression. So-called Realism, Surrealism, Naturalism, Classicism, Romaniticism, Impressionism, as well as Expressionism and Non-Objective art, all find their place in the studio. A catholicity of taste is maintained. The only prerequisite is the existence of the sensitive faculty through which the individual has collected impressions. He may have no conscious wish to communicate his thoughts, but if he is willing to work in the studio we know that he is making an effort to understand some segment of experience. The tools with which to work are given to him, and he is taught how to use them as any other skill is taught, but the important part of creative arts therapy is that he has an idea which he wishes to express.

Ninety per cent of those patients for whom art is a prescribed therapy at Winter VA Hospital have had no formal training in art. In spite of this, many first works show an amazing dexterity. This was the case with one patient who had shown no dexterity in the psychological tests which had gone before. Through a need which amounted to an inspiration, the emotional material was artistically expressed. This would seem to indicate that we have not, as yet, found an adequate test for the individual's potentiality in the use of art as treatment.

The patient may or may not be aware of the ideas that he is expressing through his artistic production. In many cases it is necessary for the physician to interpret the patient's painting to him before he understands its implications. Sometimes the meaning of the painting becomes clear to the patient after he has finished it, and this process, which we call "artsynthesis," may be dramatic and revealing. In some cases, when the patient shows no indications of any conscious realization of what he has painted, he may, nevertheless, show a clinical improvement and his behavior may indicate that he is working out an unconscious conflict through his painting. This seems to be a self-limited process which often results in a psychological resolution, and incidentally in a most interesting series of paintings through which the patient's progress can be traced.

This means that the patient needs the constant help of his doctor as he goes through these experiences in self-expression. It has been those patients

whose doctors came into the studio frequently, following each step in the studio milieu and aiding in the integration of all material expressed, who profited most directly from art therapy.

In organizing the studio for the use of art as treatment, we had excellent guidance and material aid. Dr. Karl Menninger's insight into the possible function of art as treatment, and his unfailing encouragement were fundamentally important. Our consultant from The Menninger Foundation, Dr. Edward Greenwood, gave us suggestions and criticism. The Physical Medicine Rehabilitation Service of Winter VA Hospital furnished the supplies, equipment and organization. The studio was planned to afford the best possible atmosphere for creative work, with opportunities for both expressive and vocational art, so that the patient could be guided, through suggestion and availability, toward the physician's prescribed aim.

Procedure

In over three years of experience in the use of art as treatment at Winter VA Hospital, more than a thousand patients have been sent to the art shop by their physicians. More than a dozen media were made available, but the principal ones used have been oil painting, modeling in clay, and engraving.* The patient, or student as the patient is called in the studio, was given individual attention in order to discover in what manner art could function to bring about the prescribed aim, and in what medium the individual could best handle his emotional problem. In each case, the art productions were studied and placed in groups or categories according to their therapeutic function for the individual.

The Dynamics of Art Therapy

The categories which follow are not given in the order of their value, nor are they associated with particular illnesses. Any patient may use all, or only one of these categories. They merely indicate some of the functions of art for the individual.

Group one includes the use of *fantasy*, or wish-fulfillment. The attitude of this group usually seems rather casual. The need may and usually does spring from deeper levels, but the productions are not indicative of this underlying dynamic, although they may give a key to the doctor which will help him aid the patient to an understanding of his problem. Sometimes the fantasies expressed may lead the patient to considerable verbalization, and this verbalization which was formerly impossible to the patient may

* I do not underestimate finger painting. It is, especially in the capable hands of Miss Ruth Faison Shaw, an excellent medium by means of which to "entice" the individual into creative experience. In addition, it has the advantage that it can be used by a therapist who is comparatively unskilled in painting, or modeling in clay.

aid in his cure. Sometimes the patient expresses fantasies which are a prophecy of what is to come as, for example, when a bedridden patient, who was only able to come to the studio in a wheel chair, painted himself out of doors in a daisy field.

The second function is that of *dexterity*, by means of which the patient builds up a façade against a threatening reality. This function is similar to the function of any skill by means of which the ego gains strength and security, with the exception that it offers the exclusiveness of the studio, the ivory tower behind which the ego can withdraw for contemplation. It must be remembered, however, that in art the individual does not withdraw into the ivory tower to become inactive, but to make an effort toward self-understanding. The façade of dexterity may become permanent if the ego cannot mature beyond this point, or it may be temporarily used until the ego has built up enough strength to adjust itself to life on a more adult level.

This dexterity façade was made use of temporarily in the case of a young unmarried white patient, formerly of the Navy, who first developed a serious case of tuberculosis. The tuberculosis was cured but a severe psychosis took its place, the psychosis entering on the use of the hands for masturturbation. His doctor interested him in painting and followed his progress in the studio closely. It took several months before the patient felt confident enough to try a complete painting, but as he became more and more interested, and found himself capable of very excellent painting, he found the solution of his masturbation preoccupation. As he made progress in the studio, he showed marked clinical improvement. He became adjusted enough to take part in many hospital activities, recovering, or at least becoming well enough to make adequate reality adjustments.

The third function which art may fulfill is that of *relief of anxiety* through the patient's representation of conflictual material. Graphic expression seems to escape the vigilance of the superego more easily than verbal or written expression, so that the aggressive and traumatic material may be depicted without the artist feeling culpable. However, *after* it has been put down graphically the artist may be able to recognize it because it is rendered in his own symbols (artsynthesis). It is sudden, and may be too much for the *maker* to tolerate without the constant help of his doctor.

If the meaning of a painting is not understood, it may be made clear to the patient by the doctor. This process was followed in the case of a young single male with the diagnosis of psychoneurosis, and anxiety state, with character disorder. His first painting depicted conflictual material which aided the doctor in the solution of his problem. Discussion of paintings and their interpretation never takes place in the studio until after it has been brought out in the patient-doctor relationship, as any interpretation in the studio makes the patient self-conscious and restrains the creative process.

With the insight gained from his first painting, this patient's choice of color changed completely and his behavior also changed for the better.

There are several ways in which patients deal with an upsurge of aggressive material. Some paint their aggressions out quite frankly in the form of knives, monstrous faces, animals, and bleak landscapes. Others obscure their aggressions by using surrealism, abstract and non-objective art, or a combination of these. Others paint out recurrent dreams. These have a peculiar power which may be due to their use of "dream language" or universal symbols.[2] They are reminiscent in their style of such painters as Marc Chagall.[4]

Others transform their anxiety into moral, social or philosophical subjects and entitle their works "Death," "Loneliness," "Good and Bad," etc. This objectification of inner and largely unconscious conflicts is often helpful to the patient and for that reason the artist is urged to title his work.

This leads to the fourth function of art therapy—that of *externalization and mastery of subjective thoughts and emotions*. A young married male with the diagnosis of psychoneurosis, anxiety type, was said by his doctor to be on the border line of a more serious break. The doctor hoped to interest him in painting to turn his preoccupations from himself and from too much reading. He had no interest in art but came because his doctor asked him to. He was too self-conscious to paint the first day, but spent a little time looking around. On the second day he was given materials and a place to work, his attention being turned toward the use of equipment and the setting up of a still life subject. He was told to try putting paint on the canvas just to *feel* the medium without paying much attention to subject matter, to start him toward "making" rather than "thinking." He painted that first still life with so much inward stress that it resembled the subject very little, and he was permitted to change the colors as he wished.

Color appeared to have special significance for him even at this early stage. He tried several still life subjects, and a scene from memory. By this time he had become accustomed to the studio, and his manner was less tense. The first thing which he painted as if it had reality significance for him was a trash can. This marked a turning point. From this time on he began to experiment with paint; it became fun. He became more friendly and sociable. He was given two weeks leave and brought back some very creditable paintings. He was far from well, but this was the beginning of a slow, steady improvement. His doctor followed his progress and came to the studio frequently, aiding the patient in understanding each step taken graphically. Through his paintings this patient was turned toward the expression of his emotions in a socially acceptable way, thus gaining some mastery over them, so that he was no longer at their mercy. When to this

process of self healing is added the understanding of the therapist and doctor, the experience becomes of conscious emotional value. This clinical progress is gradually reflected in better rapport in the studio and then in other social contacts.

Use of Color

It is interesting to see that the patient works out his problems not only in his choice of subject matter and his method of representation, but also in color. In the beginning he may reject color completely, preferring black and white, but as he improves and concurrent with his clinical improvement, color may become acceptable to him. It has been observed often enough for comment, that if a patient is going toward the acceptance of color, or is regressing away from color, there will appear at an intervening stage a flaring up of red through the black in the former, and a receding through the browns to red and then to black in the latter case. In receding through red to black the patient will express anxiety about his work.

It has been noted also that the creative faculty tends to remain on the same level in an individual, whether he is acutely ill, or well. If it can be aroused in the acutely ill, it may be only in the field of color dynamics that the illness is most apparent in most cases. This means that the acutely ill patient, if he can be persuaded to work, can produce as good work then as he will when he is oriented to reality.

There are many other uses of art as therapy than those I have indicated in describing the work in the studio. For example, there are patients who are acutely ill and have no specific creative ability who may be benefited by the use of art on the primary level, going back to that stage at which almost every child shows a desire to draw. By calling upon this latent tendency the ill adult may be drawn out of his preoccupation with his inner thoughts and, by the use of still life objects, or by other pictures which he is told to copy, be led to observe the world around him. He may be encouraged but must not be given false praise. If a therapeutic benefit results he will soon become aware that his art work is, as one patient expressed it when he became better, "lousy," and this is the point at which he may be directed toward a field in which he has better qualifications.

BIBLIOGRAPHY

1. Freud, Sigmund: *Leonardo da Vinci: A Psychosexual Study*. New York, Random House, 1942.
2. Guthiel, Emil A.: *The Language of the Dream*. New York, Macmillan, 1939.
3. Barr, Alfred M., Ed.: *Picasso: Forty Years of His Art*. New York, Museum of Modern Art, 1939.
4. Schneider, Daniel: The Psychoanalytic Approach to the Painting of Marc Chagall. *College Art Journal*, 6:115–124, 1946.

A PSYCHODYNAMIC ANALYSIS OF THE CRIMES OF PREJUDICED AND UNPREJUDICED MALE PRISONERS*

By WILLIAM R. MORROW, Ph.D.†

Recent investigations[1-6] have revealed important personality differences between individuals with a highly antidemocratic ideology and those with a more democratic approach to life. It has been found that highly prejudiced, antidemocratic subjects tend to have a poorly internalized conscience; their ego-defenses are apt to be rigid and externalized, with much use of projection and reaction-formation; they tend to be defensively concerned with "morality" and with seeking external status and power as reassurances against feelings of inner weakness. Prejudice itself appears to involve an external symbolization of the prejudiced person's unconscious struggle to keep his repressed feelings "in their place." Relatively unprejudiced subjects, on the other hand, tend to have more internalized values and less suppressive defenses; and they are apt to be more concerned with seeking love, often showing open ambivalence arising from frustration of that quest. Their more democratic, accepting attitudes toward outgroups are merely one expression of their more love-oriented approach to life. The present paper is concerned with the question of whether these opposed personality trends are expressed in different types of crimes committed by more and less prejudiced individuals.

Questionnaire Results

To answer this and other questions, the writer studied a group of prisoners‡ as a special project of the California (Berkeley) Public Opinion Study.§ The California self-administering attitude questionnaire, Form 45, was given in 1945 to 110 male prisoners of a state prison. The questionnaire includes a scale designed to measure ethnocentrism (E scale), constructed by Levinson.[1, 7] This consists of 10 statements with which the subject is asked to indicate his agreement or disagreement on a six-point scale; each statement implies hostility toward one or more major outgroups such as Jews, Negroes and foreigners. The questionnaire also includes a

* Read at 56th annual meeting of the American Psychological Association, Boston, Mass., Sept. 8–9, 1948.

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‡ This study was made possible by the cooperation and assistance of David G. Schmidt, Chief Psychiatrist, San Quentin, California, and his staff.

§ The senior staff of the study were T. W. Adorno, Else Frenkel-Brunswik, Daniel J. Levinson and R. Nevitt Sanford. Findings of the study are reported in full in *The Authoritarian Character*.[1] The writer's investigation of prisoners is reported there in full in Chapter XX, "Criminality and Antidemocratic Trends."

scale designed to measure potentially fascist attitudes (F scale), constructed by the senior staff of the study.[1, 8] The F scale consists of 30 statements reflecting such attitudes as oversubmissiveness to authority, punitive hostility toward those who deviate from conventional moral standards, "toughness," admiration for power, mysticism, and so forth.

The questionnaire sample contained a representation of all major legal offense groups, but excluded inmates who were over 55 years of age, illiterate, feebleminded, psychotic, or members of minority groups toward whom prejudice was being investigated (chiefly Jews and Negroes).

TABLE 1

Means of Different Prison Offense Groups† on the Ethnocentrism and Fascism Scales of the California Social Attitude Questionnaire*

OFFENSE GROUP	NO.	E SCALE	F SCALE
Checkwriting	44	4.45	4.76
Robbery, Burglary, Theft	31	4.63	4.39
Murder	12	4.31	4.33
Sex Offenses	23	5.02	5.33
All Offenses	110	4.61	4.73

* Scores are given in terms of means per person per item. Assuming a middle category, each item was scored on a 1–7 scale in which 7 indicates a highly ethnocentric or potentially fascist response, and 1 indicates the opposite.

† None of the differences between any two offense groups on either scale is significant at less than the 30 per cent level.

Legally defined offense groups are compared, in Table 1, in terms of mean scores obtained on the two attitude scales referred to above. The most notable feature of these data seems to be that the sex offenders obtained slightly higher means than other groups, especially on the F scale. On neither scale, however, does the difference between the means of any two offense groups approach statistical significance. From these comparisons alone, not much can be said about the meaning of different types of offense. The question arises: Would a more qualitative characterization of crimes, which brings out their underlying motivational structure, show a closer relationship to democratic versus antidemocratic orientations? Material now to be presented suggests a positive answer to this question.

The Interviewees

Fourteen prisoners were studied intensively by clinical interviews and analysis of prison case files. Eight scored in the high quartile on the E scale; six scored in the low quartile.* Both high-scorers (highly prejudiced)

* None of the 110 inmates who filled out the questionnaire scored extremely low; and the mean of the low quartile was distinctly higher than that obtained for most of

and low-scorers (relatively unprejudiced) included representation from each major legal offense group, except that there were no sex offenders who scored low.

Crimes of Prejudiced Interviewees

We may inquire first whether there are similarities among the delinquencies of the eight high-scorers. Eugene, as we shall call the first of these men, has served repeated sentences for drinking, gambling, robbery, writing bad checks, and especially, by his own description, for "fighting." "I like to fight once in a while," he declares; "I'm proud of my people . . . the Scotch-Irish . . . most of them like to fight." In another context, Eugene, unaware of the contradiction, bitterly condemns Negroes for "going around looking for trouble" and "starting a lot of fights." He "can't explain" his own "temper." He may be projecting an unconscious image of himself when he asserts that Negroes "like to cause trouble" because "they've got an inferiority complex" and "fight, trying to be big shots."

Floyd has also been jailed twice for fighting and "hell-raising" while drunk. In the Army he alternated between the guardhouse and repeated A.W.O.L.'s, which usually involved a spree with a woman. Asked to describe an example, he speaks of "a married woman as usual, beautiful, dumb." This type of heterosexual promiscuity has often been found to be a defense against ego-alien homosexual impulses, of which there is much independent evidence in Floyd's case.* After a neuropsychiatric discharge, he worked in a war plant for a month, but his fifty-nine dollars a week was, he complained, "too slow"; so he joined a gang which carried out a series of armed robberies. Floyd glories in telling of their smart clothes, their women, their "big operator" life. "We had to have money to operate on. We spent forty dollars or more for our dinner parties."

Ronald also led a career of armed gang robbery "as a business," to use his phrase. At the age of 25 he had been in prison half a dozen times for his numerous thefts and burglaries.†

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the groups who took the questionnaire.[1] All of the low-scoring interviewees were found to be mildly prejudiced when questioned as to their opinions on the "race problem." They were far less prejudiced, however, than the high-scoring interviewees.

* For example, asked what "great people" he admires most, Floyd mentions exclusively women of a certain type: "Salome, Madame DuBarry, Mata Hari." He explains that "they did their share . . . I like a woman who is capable . . . DuBarry came up from a courtesan to be the indirect ruler of her country." Again, the only woman he became attached to is described by him as almost completely frigid. Seemingly it was her sexlessness that impelled him to try to persuade her to divorce her husband and marry him.

† Ronald's sexual history has not led to conflict with the law but has involved an exhibitionistic type of semi-delinquent behavior. "I always marry spectacularly," he declares—for example "in a taxicab" or during a "dance walkathon . . . for money

Buck's delinquencies combine the "big operator" theme with sex offenses of a type suggesting defense against ego-alien homosexual impulses, which other evidence points to as a source of intense conflict in this man.* Aside from fraud, failure to provide for his family, and passing bad checks throughout the state on an extended drunken spree with a woman, he has also been arrested for "molesting" his own minor children and has served a term for statutory rape on a 13 year old girl. He blames the check-writing spree and his subsequent imprisonment on "that damn broad," who he claims made off with $6,000 he had just acquired by shrewd cattle dealing, which could have made the checks good. The social history reveals this and other business exploits of which he boasted to have been pure fabrication; Buck had actually lost a moderate inheritance by mismanagement and neglect, and had never earned any money of his own.

According to his description, Clarence's sexual experiences were largely limited to prostitutes until he married at the age of 38 (his wife being one year older). Just a month after his wife died, 11 years later, he was arrested for "molesting" four girls aged 8 to 10, who testified he felt of their genitals. He claimed that they so testified to get even with him because he wouldn't give them candy. Several years later he was sentenced for attempted rape on a 12 year old girl. Denying this offense also, he had elaborated a set of paranoid delusions that he had been "working for the people in politics to clean up the city" and that when his "candidates were not elected" the police "went after" him.

Robert felt impelled by the frigidity of his wife—whom, despite a variety of reproaches, he still speaks of as "the sweetest wife in the world"—to seek a mistress. He chose a woman who was having relations with various other men at the same time. His relationship with her was a violent and mutually contemptuous one. He tells how she often got drunk and threw things at him, and when she discovered that he had once served a prison term for forgery and theft, began to blackmail him. He finally shot her (unpremeditatedly) in a quarrel. The circumstances of this affair suggest that it involved less positive heterosexual gratification than an attempt by Robert to "prove" his masculinity.

Wilbur's offense followed eviction by his landlord, who happened to be

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(from the spectators) . . . no love there." On two occasions, after living with such a walkathon marriage partner for a few weeks, he "got tired of her" and left. Like Floyd, when he found a woman who was quite frigid, he decided he was "in love" with her and remained with her until his present imprisonment.

* Buck reveals his homosexual preoccupation by responding that "the worst crime a person could commit" is "assonomy," his neologism for homosexual intercourse per anum; by somewhat graphic fantasies about "any man that abuses any part of another man's body . . . I could never see tryin' to screw anybody in the ass . . . or let some guy give you a blow job"; by demanding to know, "You don't think I'm a sex maniac, do you?"

of Greek descent, after a quarrel about the rent. He got a knife, sought out the landlord, and gave him a fatal wound. The extreme defiance of this reaction suggests that Wilbur may have experienced the quarrel and eviction as an intolerable threat to his masculinity. Such an interpretation is reinforced by the fact that Wilbur was driven to depersonalize this conflictful experience by developing a set of racist delusions: He imagined himself as merely one more victim of "the Greek people, who like to punish the poor people" and ought all to be sent back to Greece.

Adrian, an example of the overtly effeminate and "flirty" type of homosexual, has admittedly lived since his teens as a homosexual prostitute. He has been in jail numerous times for being drunk and for homosexual "soliciting." He speaks of his life as "repulsive," complains that "men irritate me by what I think is a superior attitude," and states that "I never did like homosexual affairs." Even Adrian, with his self-emasculated homosexual submission* made a stab at compensatory "toughness" by holding up "a very big man" at the cash register of a grocery store. He attributes this in part to some glandular treatments he had just completed, which he feels made him "more masculine." The circumstances were that, while drinking at a bar, Adrian "read in *True Detective Stories* about a girl who got herself up a bunch of hoodlums and raised herself a lot of hell . . . and I figured if a little tiny thing like this girl could, I could." He proceeded to pick out a customer at the bar who was "the most mean looking and corrupt" and suggested they do a robbery together. "I didn't intend to play the active role . . . I thought he would do the dirty work but he wouldn't. So I had to." The man stood outside, urging Adrian on to enter the store and carry out the holdup.

What do these offenses have in common, psychologically—Eugene's fighting, Floyd's and Ronald's "bigshot" life of armed gang robbery, Buck's "bigshot" financier role and his and Clarence's sexual assaults on children, Robert's flight from his wife's frigidity into a violent relationship with a semi-prostitute—ending in murder, Wilbur's paranoid defiance of his evicting landlord, and Adrian's "masculine" holdup? All of these men's offenses seem to have been motivated by a need for some external "proof" of their "toughness," "strength," "power," "masculinity." Stated more psychologically, the offenses involved externalized attempts to "deny" feelings of "weakness" and "non-masculinity"—whether in the form of heterosexual inadequacy, homosexuality, submission, dependence, softness or passivity. Thus what superficially looks like direct self-expression of impulses seems actually to be a defensive denial of impulses and feelings.

* There is a good deal of evidence, much of it presented in the chapter on "Criminality and Antidemocratic Trends" in *The Authoritarian Character*,[1] that Adrian adopted a submissive homosexual orientation in defense against traumatic castration anxiety. This was stimulated by fear of an austere military father and an infantile socialite mother given to violent temper tantrums, both of whom neglected him.

Crimes of Relatively Unprejudiced Interviewees

Turning to consider the crimes of the low-scorers, we may note first that Art says he acted out the same pattern twice with his first wife and again with his second wife. Both are described as considerably older than himself, and like his mother, "business women, wage earners, and providers." In each instance Art got himself fired from a job and made only half-hearted efforts to get another, until "my wife as provider and support was no longer a tolerable condition to me consciously." Then he "got plastered" and wrote some bad checks. Unlike Buck, who led the authorities a merry chase, Art says "I knew I was going to get caught" but took no precautions against this, though "I used alcohol" to "insulate" against awareness of the consequences. Art volunteers the self-interpretation, arrived at by a soul-searching "autopsychoanalysis" during his present term in prison, that he suffers from "a dependency complex" and unconsciously "transferred my dependency on my mother" to "my wife," and then "onto the prison authorities." "And if you don't think prison can satisfy dependency," he declares, "you ought to try it."

Don, too, suffers from overattachment to his mother, whom he describes as "governed by emotional biases." Her third husband, he says, was "taking her for a great deal of money," which the man lost in a series of wildcat schemes. Eventually she went into debt, mortgaging her remaining property. Don tried in vain to persuade her to divorce the man, and inhibited conscious wishes to kill him. Finally, to pay her debts and continue supplying her with money, Don himself borrowed heavily and then carried out a series of bank robberies (by himself). When he was cornered by a bank official after a wild auto chase, he could not bring himself to shoot his lone pursuer in order to escape, but surrendered instead.

Dick, whose parents' interference stopped him from marrying his boyhood sweetheart because she was crippled, says he got "a wild streak," seeking escape and consolation in night life, then the Marines, then a hasty marriage that turned out badly, then again the Marines and heavy drinking. While on a furlough, he got drunk with a girl-friend with whom he impulsively "picked up a car" to drive to Reno, where they sold the car and got married while drunk. He attributes this act to "loneliness." The marriage was annulled, Dick made civil restitution for the theft, and since his imprisonment he and the crippled girl "back home" have corresponded and plan to marry. The Marines and the drinking probably symbolized in part an assertion of "manliness," but Dick's description suggests that they were associated more basically with feelings of dependent longing and despondency.

Jim attempted suicide at the age of 19 when his sweetheart quit him because his struggle to support his mother left no prospects of his marrying and supporting a wife. Not long after, while out drinking with an older

woman, he stole an auto for a joy-ride and kept it several days, for which he spent a year in a reformatory. One night shortly after his release, while quite drunk, he accosted a middle-aged woman and asked her for money. When she suddenly screamed, he impulsively clubbed her to death, and then kissed and chewed her breasts. This symptomatic act suggests intense mother-oriented ambivalence, with specific indication of oral-dependent love frustration.

Paul's offense was a similar symptomatic act. He was living with a woman separated from her husband, by whom she had had a child—a girl then aged 4. Having been drinking one evening, Paul became very angry at the child for misbehavior. When he started to spank the child, feelings that must have been long pent-up were mobilized: as if in a fugue, he compulsively continued beating the child until she was seriously injured. "I got mad. I don't know why . . . my girl was pulling on my arm and telling me to stop . . . actually I couldn't stop . . . it was just a passion to strike her. I don't know what all I did . . . I may have kicked her." The child died from hemorrhage two days later. Paul and his sweetheart still plan to marry when he is eventually released.

Frank was out of work for some time during the depression years. When he did find a job, the company for which he worked had soon to lay him off. While searching for another regular job, he struggled to eke out a living on irregular trucking jobs, on which he routinely carried a gun for protection at night. The money his mother began to leave when she visited him hurt his pride. His wife finally left with their child to stay indefinitely with her parents. While in an eating place, preoccupied with this "nightmare" as he calls it, Frank suddenly decided to hold up two expensively dressed customers for their money, which he did. He was apprehended shortly afterwards.*

The crimes of the first four low-scoring inmates—Art's writing bad checks and transferring of dependency from wife to prison, Don's robbery for his mother, Dick's car theft for an impulsive "consolation" marriage while drunk, and Jim's symptomatic attack on the middle-aged woman—these crimes seem to express common motivations, namely needs for love and dependence directed toward a mother or mother-substitute, with ambivalence caused by frustration of that striving.

Paul's compulsive beating of his sweetheart's child is less clear. To the extent that he was asserting his disciplinary authority in a competitive struggle with the child, the beating may have involved some defense

* After serving a prison term of several years, Frank experienced difficulty finding a job that would pay enough to support himself and pay alimony to his wife, who had meanwhile divorced him. He left the state in violation of his parole, in order to be free of restrictions on the type of job permitted him. He went to work legitimately until he happened to be picked up by investigators as a suspect in another case.

against weakness. But its compulsive, fugue-like quality, combined with the fact that Paul did not attempt to moralize it, suggests that it represented mainly a direct release of hostility; jealousy toward the child as a rival for the mother's love, possibly also ambivalence toward the child's mother. These circumstances distinguish it from the paranoid context of Wilbur's attack on the landlord, and from the mutually exploitive pseudo-heterosexual context of Robert's shooting of his mistress.

Frank's holdup to get money when he couldn't find a job may be slightly different in its motivation. But this and all the other low-scoring inmates' offenses have one aspect in common, reflecting the dynamic structure of their ego-defense system: Their crimes seem to involve direct expression of underlying feelings, positive or negative, or of a quest for positive need gratification. This is in contrast with the crimes of the high-scoring inmates, which seem to represent efforts to negate underlying feelings and impulses, and keep them out of awareness. These differences are consistent not only with the general personality differences between prejudiced and unprejudiced inmates revealed in their interviews[1] (Chap. 20), but also with the statistical differences in personality characteristics found by Frenkel-Brunswik[1,2] in the interviews of 40 prejudiced and 40 unprejudiced subjects from a variety of groups, by Aron[1] in Thematic Apperception Tests stories told by 40 prejudiced and 40 unprejudiced subjects from various groups, and by Levinson[1] in Projective Question responses of large numbers of prejudiced and unprejudiced subjects in various groups.

Suggestions for Further Research

The apparent differences between the crimes of prejudiced and unprejudiced inmates seem to indicate that a criminal offense tends to express the underlying motivational and ego-defense structure of the offender. The present paper has been focused upon a very broadly conceived differentiation between crimes representing defense against weakness as opposed to crimes expressing love-oriented dependence and ambivalence. The individual differences in the crimes within each of the two groups suggests that, for typological purposes, a finer differentiation might be desirable. This might well take the direction of specifying the particular kind of "weakness" which a subject is most anxious to deny, and the particular "proof" of "masculinity" which he characteristically seeks; of noting the extent to which a subject's love-oriented dependence is conscious and his hostility unconscious, or vice versa. Further, a mixture of defense against weakness with love-oriented dependence and ambivalence may distinguish the offenses of many inmates, especially those falling in between our high and low-scorers with respect to antidemocratic trends. To specify the degree and nature of this mixture for different inmates might be a rewarding task.

Several purposes might be served by this type of analysis. In the first place, it points to psychologically meaningful ways of defining criterion groups for comparison in systematic personality research. Such groups ought to yield more significant comparisons with each other or with control groups, than do legally defined groups of offenders. In the second place, this mode of classification might prove to be of considerable value for prognosis and therapy.

It is the writer's hypothesis that, in general, inmates who score low on the questionnaire scales, and whose offenses express mother-oriented needs for love and dependence, would be more responsive to psychotherapeutic efforts than high-scoring inmates whose crimes express anti-weakness themes. This hypothesis is based on the former group's apparently less rigid defenses, more internalized conscience and greater capacity for identification with other people. Such prognostic evaluations might be made in terms of questionnaire scores alone, independently of analysis of the offenses themselves. Beyond this, however, it might turn out that within, say, a group of low-scoring inmates whose offenses express a common motivational complex, those who express these conflicts in one type of offense are more responsive to therapy than those who express them in another way. Moreover, where group psychotherapy is being conducted, a dynamic typology of criminals, like the one indicated in this paper, might provide a suitable basis for selecting homogeneous groups. In any case, an understanding of the inmate's delinquency in terms of underlying dynamics should facilitate intelligent planning of efforts at psychotherapy or rehabilitation.

BIBLIOGRAPHY

1. Adorno, T. W., Else Frenkel-Brunswik, D. J. Levinson and R. N. Sanford: *The Authoritarion Character*. New York, Harper, 1949. (Forthcoming publication.)
2. Frenkel-Brunswik, Else: Dynamic and Cognitive Categorization of Qualitative Material. II. Application to Interviews with the Ethnically Prejudiced. *J. Psychol.*, 25:26–277, 1948.
3. Frenkel-Brunswik, Else, and R. N. Sanford: Some Personality Correlates of Antisemitism. *J. Psychol.*, 20:271–291, 1945.
4. Frenkel-Brunswik, Else, D. J. Levinson and R. N. Sanford: The Antidemocratic Personality. In *Readings in Social Psychology*, E. L. Hartley and T. M. Newcomb, eds. New York, Holt, 1947.
5. Hartley, E. L.: *Problems in Prejudice*. New York, King's Crown Press, 1946.
6. Hartley, E. L., and R. E. Hartley: Tolerance and Personality Traits. In *Readings in Social Psychology*, E. L. Hartley and T. M. Newcomb, eds. New York, Holt, 1947.
7. Levinson, D. J.: An Approach to the Theory and Measurement of Ethnocentrism. *Amer. Psychologist*, 2:412 (ab.), 1947.
8. Sanford, R. N.: The Measurement of Implicit Antidemocratic Trends. *Amer. Psychologist*, 2:412 (ab.), 1947.

JAMES KING HALL*
(1875–1948)

By KARL MENNINGER, M.D.

In James King Hall, on September 10, 1948, this Association lost a most beloved ex-president. All of us who shared the steady warmth and deep loyalty of his friendship know how unstintingly he gave of himself. He was never ashamed of showing his overflowing capacity for giving love.

Many of us here today, when we think of J. K. Hall, will think first of the many precious little things, tokens of his affection and thoughtfulness, which in the final count attest the bottomlessness of the heart that conceived them. We remember the warm hospitality that characterized visits with Dr. and Mrs. Hall at their home in Richmond and the joy he took in showing the historic sites about the city, vividly conjuring the past before our eyes in the light of his really great knowledge of the history of the South. We remember the many warm, personal letters in which his sensitive scholarship was blended with gentle, wise humor. We remember the gifts that arrived from time to time—books, the seeds of a tree to plant on one's lawn, a crate of sweet potatoes grown at the Westbrook farm, or beautiful flowers which he himself picked from the gardens of Westbrook Sanatorium.

He was a grand and gracious gentleman of the old school, was J. K. Hall. He seemed to extend the Southern tradition of hospitality to embrace all his colleagues of this association in a sort of gracious, genial, affectionate neighborliness. This amazing capacity of his to maintain so many friendships on a highly personal level greatly endeared him to his colleagues, but it was also probably at the core of his success as a doctor and psychiatrist.

One of his lifelong friends, Dr. William MacNider, former Dean of the Medical School of the University of North Carolina, wrote of him: "There was no commencing or ending to his day of toil for others. Sundays were not spent at ease at church or at home with the charm of his family. Such Sabbath days of rest more than likely found him in some jail or other penal institution in which he searched the inmates for a physical basis for their mental aberrations as crime, and not infrequently he was successful. Or perhaps he spent hours upon hours with a father or a mother distraught with sorrow over a mental situation in their family. He gave and gave until the end. The greatest contributions of this man are unknown and unknowable. They may be found in the deep and inner life of innumerable

* Tribute to Doctor Hall delivered by Dr. Karl Menninger at the annual meeting of the American Psychiatric Association, Montreal, Canada on May 23, 1949.

human beings far removed from any organized medical assistance who came to him as father-confessor and mental adjustor to be re-related to life as they had to live it."

James King Hall was born on his family's plantation near Statesville, North Carolina, on September 28, 1875. His father was a general practitioner, and James and his five brothers and sisters were reared according to the rigorous scholastic tradition of their Scotch-Irish forbears who were doctors, preachers and teachers. He graduated from the University of North Carolina *magna cum laude* in 1901. There, he was awarded membership in Phi Beta Kappa, and completed his first year in the Medical School during his senior year as an under-graduate. After a fifth year at the University, as a second-year medical student, he transferred to Jefferson Medical College in Philadelphia, where he received his medical degree in 1904. It was during his interneship at the Polyclinic Hospital and College for Graduates in Medicine, in Philadelphia, that Doctor Hall first became interested in neurology and psychiatry. Under the guidance and inspiration of Dr. William G. Spiller, who was director of the neurological clinic of the Polyclinic Hospital, and Dr. F. X. Dereum, one of the pioneer neuropsychiatrists of the city, the young student was early imbued with the high respect for scientific integrity which was so deeply imbedded in his subsequent life.

Doctor Hall's career in psychiatry began with his appointment as assistant physician to the medical staff of North Carolina's state hospital at Morganton. There he availed himself of the opportunities for research which Dr. Patrick L. Murphy, superintendent of the hospital, provided for his young associates, to carry out investigations on pellagra. His felicitous association at Morganton with Dr. Paul V. Anderson and Dr. E. M. Gayle led to their establishment of the Westbrook Sanatorium in 1911, on land which the three men purchased on the outskirts of Richmond. From that time until his death, Doctor Hall was president of the Westbrook Sanatorium, and under his guidance it became one of the most progressive private psychiatric hospitals in the country.

It was inevitable that a man of Doctor Hall's broad cultural background, fine intelligence and deep loyalties should find himself a leader among his colleagues. He served as president of the Richmond Academy of Medicine, the Tri-State Medical Association of Virginia and the Carolinas, the Association of Private Psychiatric Hospitals, and the Southern Psychiatric Association. His active leadership in local and state medical societies bears witness to his staunch conviction that psychiatry should be integrated both in its theory and in its practice with the other medical specialties, and that a psychiatrist should be first of all a good doctor. Doctor Hall held active membership in the National Committee for Mental Hygiene, the Virginia and North Carolina Medical Societies and the American Association for Mental Deficiency, as well as in a number of philanthropic and cultural

organizations. In 1935 he was awarded an honorary LL.D. by the University of North Carolina.

Doctor Hall put his heart into serving the American Psychiatric Association. He served on its Council for many years, and when he was elected its president in 1941, he worked more than almost any other president toward making it an active, vigorously functioning organization fulfilling the professional needs of its members. His many personal friendships with its members, his broad vision and cultural background enabled him to accomplish a great deal toward extending and stimulating the activities of our association during that year. A distinctive feature of his administration was his interest and efforts in broadening the general cultural background of psychiatrists, particularly the younger members of the association.

His scholarly attributes and his flair for historical research came prominently to the service of our association in his superb editorship, with Doctor Zilboorg, of *One Hundred Years of American Psychiatry*, published in 1944, the definitive historical document of the development of psychiatry in this country. Through his extensive contributions to the medical literature, Doctor Hall will be remembered as a leading proponent of the cause of mental hygiene and preventive psychiatry in the south. He had love for his country and a feeling for its past, which led him to become one of the foremost authorities on the history of his state of Virginia. He had really an encyclopedic knowledge of the lives of its great men and of the battles of the Civil War. Despite his pride in the traditions of the South, there was no trace in him of sectionalism or of bitterness.

His remarkable capacity to give of himself with such abandon to his patients and to his friends was due in no small degree to his wife, Laura Ervin Hall, whose graciousness, charm and fine intelligence are an inseparable part of our treasured portrait of J. K. Hall. The strength and fineness of both are blended in their three sons, James King, Jr., Dorman Thompson and Samuel Ervin.

If we should search for one distinctive characteristic as the wellspring of all that James K. Hall means to us, it would probably be the quality of reverence. His reverence for truth, blended with his reverence for tradition and for the past, accounts for his high stature among us as a scientist, progressive and yet well poised among passing fads in treatment and in theory. His reverence for the uniquely individual in men was the heart of his distinguished success in interpersonal relationships, both among his many friends and among his patients. Doctor Hall had, too, a profound reverence for God; he was a good Presbyterian. But above all he was a good man, in every sense of the word, a man who loved greatly and was greatly loved. He demonstrated again that more important than technical proficiency, more important than erudition, and more important than professional skill—all of which J. K. Hall possessed—a good psychiatrist is a man of good will, good character and good heart, who loves his fellow men.

BOOK NOTICES

Power and Personality. By HAROLD D. LASSWELL. Price $3.00. Pp. 262. New York, W. W. Norton and Co., 1948.

Although bristling with all the paraphernalia of precision in thinking—a multitude of definitions and classifications—this volume of Salmon Memorial Lectures displays occasional lapses into vagueness, lapses which might hardly require comment if they were not encountered in an exposition which seemed so rigorous. What Lasswell has attempted is, however, a difficult and important task: an analysis of the dynamics of power, and of personality as it relates to power. Many of his definitions and insights seem highly fruitful and are illuminated through historical examples and case history material. He also examines many of the crucial problems, particularly those of leadership, which confront democratic society today, and he assesses the responsibilities of the various "policy sciences," including social psychiatry. The book contains an appendix by Lasswell and Abraham Kaplan, "On Power and Influence," in which a systematic categorization of political concepts (presumably lying at the basis of the lectures themselves) is presented. This is a significant and provocative book. (Louisa P. Holt)

Marriage Counseling Practice. By JOHN F. CUBER. Pp. 175. Price $2.25. New York, Appleton-Century-Crofts, Inc., 1948.

Doctor Cuber, professor of sociology at Ohio State University, describes marriage counseling as an "emerging profession," a branch of "general psychotherapy." He says that psychotherapy has had two roots, one by way of psychiatry based on medicine and the other by way of the various behavior sciences such as psychology, sociology and education. This book is based primarily on the sociological approach although the author recognizes the need for help from psychology, psychiatry, social service and to a lesser extent, religion. (Jean Lyle Menninger)

Medical Hypnosis. By LEWIS R. WOLBERG. Price, $12.00. 2 vols., pp. 962. New York, Grune & Stratton, 1948.

Wolberg considers hypnosis as an important therapeutic tool, the application of which must be guided constantly by dynamic principles of psychotherapy. While adhering consistently to psychoanalytic principles, the author demonstrates the importance of a flexible approach in treatment, being guided by practical, as well as purely psychiatric factors. He presents what may appear to some a rather daring range of "techniques," varying from authoritative, direct suggestion of symptom removal, to hypnoanalysis. The author succeeds, in general, in demonstrating that hypnosis can be an effective therapeutic tool, and he presents a good argument for the practical necessity in many instances for short term psychotherapy. Wolberg seems pretty much aware at all times of the limitations of "short-cut" techniques, and stresses throughout the volumes the importance of the therapist's being aware of the goal of therapy and of the reality factors which influence its attainment. (Gerald A. Ehrenreich)

Masterworks of Science. Digests of Thirteen Great Classics. JOHN WARREN KNEDLER, JR., ed. Price, $4.00. Pp 646. New York, Doubleday & Company, Inc., 1947.

Doubleday and Company have been publishing a "Masterworks Series," reprinting for example, under masterworks of government, such classics as Plato's *Republic*, Machiavelli's *Prince* and Lenin's *State and Revolution*. They have published similar collections of classics in science, economics, philosophy, and autobiography. The one on science came out in 1947, and contains such things as Euclid's original treatise *The Elements*, Galileo's *Dialogues*, Newton's *Principia*, and so on down the line through Darwin, Faraday, Mendel, Mendeleyev, Curie, and Einstein.

Just dipping into almost any of them and reading for a little while is a rather thrilling experience—humbling and inspiring at the same moment. (Karl Menninger, M.D.)

Child Offenders. By HARRIET GOLDBERG. Price $4.00. Pp. 215. New York, Grune & Stratton, 1948.

The author combines a wealth of juvenile court experience with a psychiatric point of view in a successful attempt to dispel some of the confusion surrounding the problem of delinquency. Written in non-technical language, it is of particular value to child welfare and juvenile court workers, but could be profitably read by all psychiatrists, psychologists, and others interested in attacking this problem. The author recognizes that the roots of delinquency are interwoven into the familial and social environment of the individual and avoids the error of suggesting a panacea; instead she calls on all the resources of the community to unite in working toward prevention, early detection, and enlightened treatment. (Thomas S. Harper, M.D.)

The Challenge of Parenthood. By RUDOLF DREIKURS. Price $3.50. Pp. 334. New York, Duell, Sloan and Pearce, 1948.

Dreikurs has had considerable experience in child psychiatry and is apparently much influenced by Adlerian psychiatry. His book is instructive and calculated to promote awareness in parents of the psychological implications of the parent-child relationship. There is, however, one serious drawback to it. Its attitude is more remedial than prophylactic. Despite the author's specific reassurances to the contrary, its general approach is as likely to arouse anxiety as to allay it. Throughout, there is a note of correction, pressure and imminent disaster.

While commendably advocating firmness, consistency and order in the rearing of the child, the author constantly gives the impression of a tendency to sternness and an "iron hand in the velvet glove" which escapes the bounds of a relaxed parental attitude. Despite these limitations, the book is still very useful reading for parents. (Maimon Leavitt, M.D.)

Adam's Rib. By RUTH HERSCHBERGER. Price $3.50. Pp. 221. New York, Pellegrini & Cudahy, 1948.

The author writes with considerable acerbity, irony and sarcasm concerning the condescension shown by some male scientific writers when they discuss female psychology. She feels that prevalent prejudices obscure an ob-

jective appraisal of female sexuality as well as having a deleterious affect upon adjustment between the sexes. (Karl Menninger, M.D.)

The Psychology of Abnormal Behavior. By LOUIS P. THORPE AND BARNEY KATZ. Price $6.00. Pp. 878. New York, The Ronald Press Co., 1948.

The authors have presented an all inclusive coverage of the field of abnormal psychology and the text may not only be useful for new students of abnormal behavior, but may be a useful reference for the practicing clinician as well. In many ways the book has the characteristics of a manual. Almost all of the nosological categories are vividly illustrated by actual cases. The most recent literature and research has been carefully surveyed and is presented to document various topics under consideration. The authors purpose is "to present the essential facts, findings and interpretations of abnormal psychology which the extensive literature has developed." On the whole they have accomplished their aim. (Bernard Steinzor, Ph.D.)

Music and Medicine. Edited by DOROTHY M. SCHULLIAN AND MAX SCHOEN. Price $6.50. Pp. 482. New York, Henry Schuman, Inc., 1948.

This is an excellent series of sixteen essays on the emotional effects of music upon primitive peoples, sick patients, industrial workers, and people in general. It has an excellent, very extensive bibliography (64 pages). Both the essays and the bibliography make it an indispensable addition to the literature of a neglected field of therapy. (Karl Menninger, M.D.)

Transference in Casework. By RICHARD STERBA, BENJAMIN H. LYNDON, AND ANNA KATZ. Price $0.75. Pp. 51. New York, Family Service Association of America, 1948.

This little monograph consisting of three papers written respectively by a psychoanalyst, an associate professor in a school of social work, and a psychiatric social worker, is an attempt at further clarification of the subject of transference in casework. It is instructive material for the beginning therapist, whether psychiatrist or social worker. Doctor Sterba's contribution, and the detailed case study by Anna Katz, are especially valuable because they do not scorn the "obvious" which, after all, only becomes so after one has had considerable experience in working with patients. (Ruth Cohn)

CORRECTION

It has been called to my attention that in reviewing *Sociometric Studies of Grouping and Regrouping* by Moreno and Jennings, I erred in not recognizing that the work of these authors antedated and partly inspired the "group atmosphere" experiments of Lippitt and his associates.

LOUISA P. HOLT, PH.D.

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